DIVISION OF CHILD MENTAL HEALTH SERVICES
DISCHARGE FROM OUTPATIENT MENTAL HEALTH SERVICES

Client Name	DOB

Date of Discharge	Agency
Therapist Name	Telephone

Update information only if different from admission form:

Address	County K S NC Other	Telephone #1
City/State/Zip _____	SSN _____	Telephone #2 ____

Reached age of 18 ___ yes ___ no

Reason for Discontinuation	Referral at Discontinuation	
01 Transferred - responsibility for the patient officially accepted by another organization and client transferred to that organization	01 Family	14 Group Home
02 Administratively Discontinued (no contact with client for 90 days or more)	02 Court/YRS	15 MH Residential
03 Client died	03 School system	16 SA Residential
04 Client/family terminated services against advice	04 DFS	17 DCMHS Outpatient MH
05 Client/family moved from the area	06 Other Social Service Agency	18 DCMHS Outpatient SA
06 Treatment completed no referral	07 DCMHS Central Intake	19 DCMHS Day MH Day
07 Additional services needed - Referral made	08 DCMHS Clinical Team	20 DCMHS SA Day
08 Additional services needed - No referral made	09 Primary Care Physician	21 School Wellness Clinic
09 Other (Specify)	10 MCO_____	22 Adult Services
	11 General Hospital	Other _____
	12 Psychiatric Hospital	_____
	13 Private MH Practitioner	

Outcome of treatment – Compare Problems Listed on Admission Form – Status at Discharge

	Symptoms Worse			No Change		Greatly Improved	
1._____	1	2	3	4	5	6	7
2. _____	1	2	3	4	5	6	7
3._____ _____	1	2	3	4	5	6	7

DSM-IV Diagnosis Upon Discontinuation

Axis I (Primary)	Code:
Axis I (Secondary)	Code:
Axis II:	Code:
Axis III.	Code:
Axis IV:	Code:
Axis V:	